Filed 12/2/04 Reyome v. Sunrise Senior Living Services CA2/6

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SIX

GARY REYOME,

Plaintiff and Appellant,

v.

SUNRISE SENIOR LIVING SERVICES, INC.,

Defendant and Respondent.

2d Civil No. B174986
(Super. Ct. No. CIV218513)
(Ventura County)

Gary Reyome, individually and as the surviving heir of his deceased mother, Gwendolyn Reyome, brought an action against respondent Sunrise Senior Living Services, Inc. (Sunrise), seeking damages for, among other things, elder abuse (Welf. & Inst. Code, § 15657) and wrongful death.[1] The trial court granted Sunrise's motion for summary adjudication of the elder abuse claim. The case proceeded to trial on the wrongful death claim and the jury awarded him damages. He appeals, contending the court erred in summarily adjudicating the elder abuse claim. We affirm.

[1] All statutory references are to the Welfare and Institutions Code unless otherwise stated.

Factual and Procedural Background

In 2000, Gwendolyn, age 82, was admitted to Brighton Gardens of Camarillo, a skilled nursing facility owned and operated by Sunrise. Gwendolyn suffered from dementia and Alzheimer's disease. While residing there, her physical and mental condition deteriorated.

On November 4, 2002, at 6:45 p.m., two certified nursing assistants (CNA's) attempted to transfer Gwendolyn from her wheelchair into her bed. During the transfer, she fell and hit her head on the bedrail. She was placed in her bed and monitored. At 8:30 p.m., Gwendolyn vomited. At 9:40 p.m., she vomited again, was nonresponsive, and appeared comatose. At 9:54 p.m., the supervising nurse made arrangements to transfer Gwendolyn to St. John's Pleasant Valley Hospital where she died a few hours later. A medical examiner determined that the cause of death was blunt force head trauma.

In March of 2003, appellant initiated this action, seeking damages against Sunrise based on four theories: (1) elder abuse under the Elder Abuse and Dependent Adult Civil Protection Act, section 15600 et. seq (hereinafter the Elder Abuse Act); (2) statutory violations of a patient's rights under the Long-Term Care, Health, Safety, and Security Act (Health & Saf. Code, §§ 1417, 1430, subd. (b)); (3) unfair business practices; and (4) wrongful death. Appellant alleged that the serious head injury Gwendolyn suffered as a result of her fall and the delay in transferring her to the hospital were substantial factors in her death.

Appellant's cause of action for elder abuse alleged that Sunrise negligently, carelessly or recklessly failed to provide Gwendolyn with emergency medical care, failed to notify the attending physician of her fall and sudden changes in her vital signs and symptoms, and failed to arrange for a physician to be available to furnish emergency medical care if her attending physician was unavailable. Appellant alleged that, as a proximate cause of these actions, Gwendolyn suffered injuries and emotional distress, and incurred medical expenses. Appellant sought recovery of the medical expenses, damages for pain and suffering, and attorney's fees. (§ 15657.)

Thereafter, Sunrise moved for summary adjudication of the elder abuse claim on the ground that appellant could not establish one or more of the essential elements under section 15657. Specifically, Sunrise contended there were no triable issues of fact showing that it had acted recklessly with respect to Gwendolyn's care or condition. Rather, Sunrise argued, the undisputed facts showed that her fall was an accident. In support of its motion, Sunrise offered the declarations of the two CNA's that had assisted Gwendolyn in transferring her from her chair to her bed on the day of her fall, Juliet Isaac and Judy Fajardo. Their declarations set forth the following undisputed facts:

Isaac and Fajardo were certified as CNA's in January and February of 2002, respectively. Both women had worked full-time at Brighton Gardens since July of 2002. Their duties included providing personal care and assistance to residents with daily living activities, such as bathing, toileting, dressing, grooming, oral care, and eating. When first hired by Brighton Gardens, both Isaac and Fajardo participated in a full day of orientation, followed by several days of on-the-job training covering all aspects of the job. As part of that training, they received a one-hour course on body mechanics, lifting, and safe transferring techniques.

During a usual shift, Isaac transferred Gwendolyn at least twice: once from her bed to her wheelchair and then once back to bed. Prior to her fall, Isaac had transferred Gwendolyn over 120 times without incident. When transferring Gwendolyn, she always obtained the assistance of another CNA to help steady her because Gwendolyn could not bear weight and she was often combative. Isaac stated that Gwendolyn regularly grabbed her hands, waived her fists in the air, stiffened her body, and screamed and cried, making it difficult to assist her. Fajardo had previously participated in transferring Gwendolyn at least 25 times without incident.

There were two different techniques that Isaac and Fajardo used to transfer Gwendolyn from her wheelchair to her bed, depending on whether she was combative. When she was not combative, Isaac and Fajardo would stand on either side of her, put one arm underneath her armpit, lift her to her feet, pivot her so she could sit down on the edge of the bed, and then assist her into bed. When she was combative, Fajardo would stand

closely behind her during the transfer, steady Gwendolyn with her leg, and hold onto the waistband of Gwendolyn's pants. Isaac would then stand in front of Gwendolyn, wrap her arms under Gwendolyn's armpits in a bear hug, and lift Gwendolyn to a standing position. Fajardo would then move the wheelchair out of the way, allowing them to pivot Gwendolyn onto the bed. They never used a mechanical lift or gait belt to transfer Gwendolyn because she was often combative.

On November 4, 2002, Isaac asked Fajardo to help transfer Gwendolyn to bed. Because Gwendolyn was combative and resisting care, they decided to use the transfer method where Isaac stood in front and Fajardo stood closely behind Gwendolyn. They positioned the wheelchair close to the bed, and Isaac lifted Gwendolyn while Fajardo steadied her by holding onto the waistband of her pants. Before Fajardo could push the wheelchair back, Gwendolyn stiffened her body and started shaking and crying. This caused Isaac to unexpectedly lose her balance and she fell backwards, hitting her back on the siderail of the bed. Fajardo was also knocked off balance and could not prevent Gwendolyn from falling forward. Gwendolyn fell forward and hit her head on the siderail of the bed. The fall occurred at 6:45 p.m.

After the fall, Fajardo helped Isaac get up and then they both lifted Gwendolyn off the floor and into bed. Isaac noticed a laceration on the bridge of Gwendolyn's nose and a bump on her left forehead. Isaac immediately reported the fall and Gwendolyn's injuries to Norma Dacanay, LVN, the supervising charge nurse.

Dacanay immediately came to Gwendolyn's room and assessed her. She asked Isaac to get an ice pack, the blood pressure apparatus, and a thermometer. Gwendolyn's vital signs were normal at that time. At approximately 7:05 p.m., Dacanay went to notify Gwendolyn's physician about the fall. Dacanay instructed Isaac to take Gwendolyn's vital signs every 15 minutes for the first hour, every 30 minutes for the next hour, then once an hour, and report the results and any changes to her. Isaac took Gwendolyn's vital signs again at that time and they were normal. Fajardo also checked on Gwendolyn approximately every 30 minutes even though not asked to do so.

At 7:20 p.m., 7:35 p.m., and 8:05 p.m., Isaac noted that Gwendolyn's vital signs were normal and she was responsive. At 8:30 p.m., Isaac noted vomitus in Gwendolyn's bed and reported this to Dacanay, who assessed Gwendolyn. Gwendolyn's vital signs were still normal and she was responsive and verbalizing as usual. Dacanay administered oxygen to Gwendolyn. Isaac continued to check her frequently and changed her bed linens. At 9:00 p.m., Isaac noticed that Gwendolyn was responsive and still receiving oxygen. Between 9:15 and 9:25 p.m., Isaac found Gwendolyn sleeping without any signs of a change in her condition.

At 9:40 p.m., Isaac checked on Gwendolyn and found more vomitus in her bed. Gwendolyn was nonresponsive at that time. Isaac immediately alerted Dacanay, who assessed Gwendolyn. For the first time, Gwendolyn's vital signs were abnormal and her pupils did not react normally to light. Dacanay left to contact the physician and family, and make arrangements to transfer Gwendolyn to the hospital. At 9:54 p.m., Dacanay called 911. Paramedics arrived and took Gwendolyn to the hospital. Gwendolyn died at 2:42 a.m. the next morning.

Appellant opposed the motion for summary judgment, arguing that triable issues of fact remained in dispute as to whether Gwendolyn was recklessly neglected by Sunrise. He contended the evidence demonstrated that Brighton Gardens had failed to provide medical care for Gwendolyn's physical needs and failed to protect her from safety and health hazards. His evidence showed the following undisputed facts.

Brighton Gardens has a written policy and procedure requiring that two people assist a resident in transferring to and from a wheelchair if the resident cannot stand alone. To transfer a resident from her chair to her bed, the aids stand on each side of the resident, lock arms with the resident, gently stand and turn the resident, and sit her on the edge of the bed. Isaac and Fajardo did not follow this policy on the evening in question.

Beverly Aldridge was the staff developer at Brighton Gardens during all relevant times and was in charge of the CNA training program. She had been a licensed nurse since 1965 and had never heard of a two-person transfer where one aide stands in front of and one aide stands behind the patient. CNA's at Brighton Gardens are supposed

to receive orientation on the two-person transfer technique outlined in the facility's policy and demonstrate it to the staff developer. Isaac had not received orientation at Brighton Gardens with respect to two-person transfers and instead attended a class that covered only one-person techniques. Isaac, who is 4 feet 10 inches tall, admitted she was too small to transfer Gwendolyn safely by herself.

After Gwendolyn's fall, Isaac and Fajardo put Gwendolyn in bed in violation of Brighton Gardens' written policy requiring that patients not be moved after a fall until a nurse is summoned to assess the patient. Brighton Gardens also has a written policy requiring that the attending physician be notified if there is an incident that results in an injury or there is a significant change in the resident's physical or mental condition. Finally, the facility has a written policy providing that if a resident's attending physician is not available when an emergency occurs, the on-call emergency physician must be contacted.

Dr. Suddah Nathan was Gwendolyn's attending physician. Dacanay knew Dr. Nathan's office and pager numbers. After Gwendolyn's fall, at 7:15 p.m., Dacanay sent a facsimile to the doctor's office even though she knew the office was closed at that time and no one would immediately receive the facsimile. She expected Dr. Nathan would call the next day. After Gwendolyn vomited at 8:30 p.m., Dacanay twice attempted to page Dr. Nathan with no response. After Gwendolyn vomited at 9:40 p.m., Dacanay called Dr. Nathan's office and learned that his pager was not working. Dacanay received Dr. Nathan's cellular telephone number and left a voicemail message on it. At 9:54 p.m., Dacanay called 911.

During the evening of November 4, 2002, Dacanay never called the facility's medical director, director of nursing, or administrator. Elsa Valdez, the other charge nurse on duty that evening, did not know the facility's policies with respect to contacting an alternative physician.

The Department of Health Services regulates skilled nursing facilities. Lori Dulek, a health facilities evaluator employed by the department, investigated the events and circumstances of November 4, 2002. She made the following findings: Brighton

Gardens failed to (1) implement patient care polices and procedures regarding safe transfers in violation of California regulations; (2) promptly notify Gwendolyn's attending physician of a serious accident and subsequent adverse changes in her vital signs, symptoms and behavior in violation of California regulations; (3) implement patient care policies and procedures regarding assessment of patients prior to being moved after a fall in violation of California regulations; and (4) maintain Gwendolyn's health records with correctly recapitulated physician orders in violation of California regulations. The department issued Brighton Gardens a class "AA" citation and a $60,000 civil penalty for the first violation, a class "A" citation and a $10,000 civil penalty for the second violation, and deficiencies for the third and fourth violations.[2]

Appellant also submitted the expert declaration of Roxanne Wilson, a licensed and registered geriatric nurse. Wilson opined that the care and treatment Gwendolyn received fell below the standard of care in several respects: (1) the transfer technique used by Isaac and Fajardo did not comply with the written patient care procedures of Brighton Gardens and was unsafe given Gwendolyn's size and condition and the physical limitations of the nursing assistants; (2) Gwendolyn was moved after her fall prior to being assessed by a registered nurse in violation of the standard of care and written policies of Brighton Gardens; (3) nursing staff failed to recognize both the seriousness of her head injury and the change in her condition even though vomiting and a low oxygen saturation were evidence of a serious head injury; (4) nursing staff failed to notify the attending physician, an alternate physician, the facility's medical director, or the facility's administrator of Gwendolyn's fall and change in her condition after she vomited and was noted to have a low oxygen saturation, and failed to call 911 immediately after this change

[2] Class "A" citations are violations found by the Department of Health Services to present a substantial probability of death or serious harm to a patient or resident of a long-term health care facility. Class "AA" citations are violations that meet the criteria for class "A" citations and proximately cause the death of a patient or resident of a long-term health care facility. (Health & Saf. Code, § 1424, subdivisions (c) & (d).)

in condition. Wilson opined that the deviations from the standard of care were facility wide and not just the negligent acts of one or two employees.

Wilson also opined that this was not the first time Brighton Gardens had violated the standard of care. Brighton Gardens had violated the standard of care before November 4, 2002, by failing to provide Gwendolyn with physician-ordered restorative nursing aide services. In 2000, Gwendolyn was diagnosed with a functional limitation in the range of motion of her left arm and hand. In October of 2001, her physician had ordered range of motion exercises for Gwendolyn's upper and lower extremities for 15 minutes per day, five times per week. The purpose of these exercises was to prevent contractures. A February 5, 2002, assessment identified changes in the functional limitation of her hands, but a plan of care was not developed to address the change, which then included the right hand, and Gwendolyn's physician was not notified of the change in her condition. During the months of March and April of 2002, range of motion exercises were attempted only three times. On May 7, 2002, a physical therapy screening revealed wrist and finger flexion contractures as well as resistance to passive range of motion. Brighton Gardens admitted that restorative nursing aide services were not provided for the months of March and April of 2002 due to a shortage of staff. On May 30, 2002, the Department of Health Services issued Brighton Gardens a class "A" citation and imposed a civil penalty of $20,000 for failing to provide restorative nursing aide services to its patients. In September of 2001, the department issued Brighton Gardens a class "B" citation and imposed a civil penalty for this same problem.

Following a hearing, the trial court granted Sunrise's motion for summary adjudication of the elder abuse cause of action. The court ruled: "Plaintiff has not shown recklessness, oppression, fraud, or malice, which are essential elements of the cause of action. Although the court may assume that there must be more evidence of these issues than can be provided by the lay witness who is the survivor of the decedent, such is not the duty of the court on these motions. The facts offered are insufficient and although plaintiff could have moved to continue the motion to do further discovery, plaintiff did not. Absent the special elements, there is no cause of action for elder abuse."

Thereafter, in exchange for Sunrise's admission of negligence in connection with the wrongful death claim, appellant dismissed his causes of action for statutory violation of patient's rights and unfair business practices. The case proceeded to trial on the sole issue of damages for wrongful death. The jury returned a verdict awarding appellant damages in the amount of $51,764.63, representing $1,764.63 for funeral and burial expenses, and $50,000 for loss of love, companionship, comfort, care, affection, society and support.

Discussion

"When a cause of action lacks merit as a matter of law, summary adjudication is proper." (*Intrieri v. Superior Court* (2004) 117 Cal.App.4th 72, 81; Code Civ. Proc., § 437c, subd. (f)(1).) A defendant moving for summary adjudication has the initial burden of showing that the cause of action lacks merit because one or more of the elements cannot be established or there is a complete defense to that cause of action. (Code Civ. Proc., § 437c, subd. (p)(2).) Once the defendant meets that burden, the burden shifts to the plaintiff to show that triable issues of material fact exist as to that cause of action or a defense thereto. The plaintiff may not rely upon the mere allegations of its pleadings to show that a triable issue of material fact exists but, instead, must set forth the specific facts showing that a triable issue of material fact exists as to that cause of action or a defense thereto. (*Ibid*.) "There is a triable issue of material fact if, and only if, the evidence would allow a reasonable trier of fact to find the underlying fact in favor of the party opposing the motion in accordance with the applicable standard of proof." (*Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 850.) On appeal, we apply a de novo standard of review. (*Certain Underwriters at Lloyd's of London v. Superior Court* (2001) 24 Cal.4th 945, 972.)

The elements of a cause of action under the Elder Abuse Act are statutory and reflect the Legislature's intent to provide enhanced remedies to encourage private, civil enforcement of laws against elder abuse and neglect. (*Delaney v. Baker* (1999) 20 Cal.4th 23, 33 (*Delaney*).) One of the remedial purposes of the act is to protect elder or dependent adults who are residents of nursing homes. (*Id*. at p. 40.) In order to obtain the enhanced

remedies available under the act, it must be proven by clear and convincing evidence that (1) a defendant has subjected an elder to *neglect* as defined by section 15610.57, *physical abuse* as defined by section 15610.63, or *financial abuse* as defined by section 15610.30; *and* (2) the defendant acted with recklessness, malice, oppression, or fraud in the commission of the abuse. (§ 15657.) In the context of this case, appellant must show evidence of both neglect and recklessness. Contrary to appellant's contention, evidence of neglect is insufficient in itself to establish the private cause of action.

Once a plaintiff demonstrates by clear and convincing evidence both elements of neglect and recklessness, in addition to all other remedies provided by law, the plaintiff may obtain an award of reasonable attorney's fees and costs. (§ 15657.) "Further, in a wrongful death action involving abuse or neglect of an elderly or dependent adult, damages for pain and suffering may be awarded." (*Intrieri v. Superior Court*, *supra*, 117 Cal.App.4th at p. 82; § 15657.)

Section 15610.57, subdivision (a) defines the element of neglect as "[t]he negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise." Under section 15610.57, subdivision (b), neglect includes, but is not limited to, the failure to provide medical care for physical and mental health needs, and the failure to protect from health and safety hazards.

As for the element of recklessness, our Supreme Court has held that "the acts proscribed by section 15657 do not include acts of simple professional negligence, but refer to forms of abuse or neglect performed with some state of culpability greater than mere negligence." (*Delaney*, *supra*, 20 Cal.4th at p. 32.) As *Delaney* explained, "In order to obtain the remedies available in section 15657, a plaintiff must demonstrate by clear and convincing evidence that defendant is guilty of something more than negligence; he or she must show reckless, oppressive, fraudulent, or malicious conduct. The latter three categories involve 'intentional,' 'willful,' or 'conscious' wrongdoing of a 'despicable' or 'injurious' nature." (*Id.* at p. 31.) "Recklessness" is defined as a "subjective state of culpability greater than simple negligence," involving a "'deliberate disregard' of the 'high

degree of probability' that an injury will occur." (*Ibid*.) *Delaney* emphasized that "[r]ecklessness, unlike negligence, involves more than 'inadvertence, incompetence, unskillfulness, or a failure to take precautions' but rather rises to the level of a 'conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it.'" (*Id*. at pp. 31-32.)

Appellant contends that the declaration of his expert, Roxanne Wilson, and the deposition testimony of Lori Dulek (the evaluator employed by the Department of Health Services), show that triable issues of fact remain in dispute as to whether Gwendolyn was recklessly neglected while a resident at Brighton Gardens. We disagree. Appellant's evidence showed at most that Gwendolyn's injuries were the result of negligent conduct on the part of Sunrise, not the product of willful, reckless, malicious or oppressive conduct as required by section 15657. Evidence of negligence or even gross negligence is insufficient to support a claim of elder abuse.

It was undisputed that the transfer technique utilized by the nursing aides on November 4, 2002, had been successfully and safely used on prior occasions when Gwendolyn was combative. While their technique did not comply precisely with Brighton Gardens' written procedures, there was no indication that the deviation from those procedures constituted a "deliberate disregard" for Gwendolyn's safety resulting in a "high degree of probability" that an injury would result, or that it was part of a "conscious choice of a course of action . . . with knowledge of the serious danger to others." (*Delaney*, *supra*, 20 Cal.4th at pp. 31-32.) Further, appellant presented no evidence of intentional wrongdoing or recklessness on the part of the nursing assistants or any other staff person. It is undisputed that, after Gwendolyn's fall, her condition was monitored every 15 minutes by nursing aides. It is undisputed that, as her condition worsened, the staff attempted to contact her physician and ultimately transferred her to the hospital just three hours after her fall. Although it can be inferred that the staff should have acted more quickly in transferring her to the hospital, there is no evidence that their failure to do so was based on any intentional or willful behavior, or on a conscious choice of a course of action with knowledge of the serious danger to Gwendolyn. Rather, the undisputed evidence showed

at most incompetence, unskillfulness, or a failure to take precaution. As the Supreme Court noted in *Delaney*, this is insufficient as a matter of law to meet the essential elements of a claim under section 15657. (*Delaney*, *supra*, 20 Cal.4th at p. 31.)

While the administrative citations sustained against Brighton Gardens by the Department of Health Services are certainly relevant on the element of *neglect* (see *Norman v. Life Care Centers of America, Inc.* (2003) 107 Cal.App.4th 1233, 1246), the citations do not raise a triable issue of fact as to the element of *recklessness* under section 15657. The citations provide evidence of a subjective state of culpability no greater than negligence or gross negligence.

Appellant did present evidence that Brighton Gardens failed to provide Gwendolyn with physical therapy even after being cited by the Department of Health Services. There was no evidence presented in opposition to the summary adjudication motion that the limited instances of this neglect were a substantial factor in causing Gwendolyn pain or suffering, or that they contributed to her death.

Finally, *Intrieri v. Superior Court, supra,* 117 Cal.App.4th 72, cited by appellant, is distinguishable. There, the appellate court reversed a summary judgment in favor of a nursing home, concluding that triable issues of fact remained in dispute as to the reckless conduct element of the elder abuse cause of action. Mrs. Intrieri was injured and ultimately died following an unprovoked altercation with a non-Alzheimer's patient who had entered the Alzheimer's unit. The court found a reasonable inference of conscious disregard of the safety of the Alzheimer's patients where the evidence showed that the nursing home provided unfettered access to the vulnerable residents of the Alzheimer's unit to anyone who could read the code posted over the keypad, and Mrs. Intrieri developed untreated bedsores on her right foot that eventually led to amputation of her right leg below the knee. As for the bedsores, the evidence showed that Mrs. Intrieri's son had observed the sores on his mother, complained that they were not being treated, and hired an outside physician to develop a new care plan for the sores. When the nursing home staff failed to follow the new care plan, the son confronted the staff again, but

nothing was done. The sores ultimately became infected, which led to the amputation of her leg. (*Id*. at pp. 84-85.)

Unlike *Intrieri*, appellant did not present evidence of reckless neglect or show a "'conscious choice of a course of action . . . with knowledge of the serious danger to others involved in it.'" (*Delaney*, *supra*, 20 Cal.4th at pp. 31-32.) The evidence showed that, after her fall, Gwendolyn was frequently monitored by nursing staff until she was transferred to the hospital just three hours later. The evidence submitted in opposition to the summary judgment motion showed at most negligence or gross negligence on the part of the nursing staff at Brighton Gardens, which is insufficient for an elder abuse claim.

The judgment is affirmed. Costs on appeal are awarded to respondent.

NOT TO BE PUBLISHED.

COFFEE, J.

We concur:

GILBERT, P.J.

PERREN, J.

Steven Hintz, Judge

Superior Court County of Ventura

Law Offices of Gregory L. Johnson, Gregory L. Johnson, Marc D. Anderson for Plaintiff and Appellant.

Hanson, Bridgett, Marcus, Vlahos & Rudy, James A. Napoli, Michael B. McNaughton, Glenda M. Zarbock for Defendant and Respondent.